Advance Action Notice:

An Advance Action Notice must be sent when the current applicant is receiving program services, but is **no longer functionally eligible** for services based on the Michigan Medicaid Nursing Facility Level of Care Determination and attempts at discharge planning have failed. The Nursing Facility Transition Team is available to assist.

Advance Action Notices must also be sent to **current** MI Choice Program participants whose services, based upon the Michigan Medicaid Nursing Facility Level of Care Determination, will be reduced/suspended.

(MI Choice Provider Letterhead)
Adverse Action Notice
Advance Action Notice

Reduction/Suspension of Services

Date:

Name:
Address:
City, State, Zip code

Dear _____:

Following a review of your long term care needs based on the Michigan Medicaid Nursing Facility Level of Care Determination, it has been determined that there will be a change in your MI Choice Waiver services.

The following services: _____ will be _____ (*reduced or suspended*). The effective date of the above mentioned MI Choice Program services will be 12 days from the date of this notice. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request the following:

Medicaid Fair Hearing: To request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

Administrative Tribunal
Michigan Department of Community Health
PO Box 30763
Lansing, Michigan 48909

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action stated above.

Sincerely,
(provider representative)

(MI Choice Provider Letterhead)
Adverse Action Notice
Advance Action Notice

Termination of Services

Date:

Name:
Address:
City, State, Zip code

Dear _____:

Following a review of your long term care needs, it has been determined that you no longer qualify for MI Choice Program services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies.

The effective date of MI Choice services will be 12 days from the date of this notice. The legal basis for this decision is 42 CFR 440.230 (d).

Services Affected: _____

If you do not agree with this action, you may request all or any of the following:

Immediate Review: To obtain an Immediate Review, you must contact the Michigan Peer Review Organization (MPRO) at 800-727-7223 before 12:00 PM (noon) of the next business day following your receipt of this notice.

Medicaid Fair Hearing: To request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

Administrative Tribunal
Michigan Department of Community Health
PO Box 30763
Lansing, Michigan 48909

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action stated above.

Sincerely,
(provider representative)